Williamson County Basic Term Life Insurance

FOR EMPLOYEE TO COMPLETE GROUP PLAN #: 93624

EMPLOYEE NAME *(last name, first, middle initial)*		EMPLOYER NAME **WILLIAMSON COUNTY**	
EMPLOYEE ADDRESS *(street, city, state, zip code)*		SOCIAL SECURITY NUMBER	DATE OF BIRTH
SEX ☐ *Male* ☐ *Female*	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION

VOLUNTARY DEPENDENT COVERAGE ELECTIONS

Amount of coverage selected for:
You have the opportunity to elect basic life insurance for your dependent(s). You may elect coverage for your spouse in the amount of $5,000 and $2,500 for each of your child (ren) between the ages of 15 days & 19 years (25 years if a full time student).

Life Your Spouse: $ _____ Each Child: $_____

☐ I **elect** to enroll my spouse and/or child(ren) in the supplemental life plan at a monthly cost of .63 per family unit

☐ I **decline** the supplemental life plan for my spouse or child(ren)

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval. If you DO NOT APPLY FOR coverage for you or your dependent(s) during the 31-DAY initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.

Beneficiary Information *Designate your beneficiary(ies) below.*

NAME OF BENEFICIARY *(last name, first, middle initial)*	RELATION TO YOU	BENEFIT %
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

REQUEST FOR SIGNATURE *Please read the back of this form carefully before signing below.*

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ __ __/__ __/__ __ __ __ _____ _____

Employee Signature Date Work Phone Home Phone

Limitations and Exclusions

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect.

Dependents Only:

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.